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ABSTRACT

The purpose of this study was to analyze select personality characteristics of individuals working within the Acquired Immune Deficiency Syndrome (AIDS) population in comparison to non-AIDS caregivers by using two personality assessment instruments. Subjects were from two health care provider populations. Two hundred research packets were distributed to various AIDS and non-AIDS service organizations and health care facilities, with a return of 64 usable packets, which represented 2 groups. The first group of 32 dealt only with Persons with AIDS (PWAS). They provided counseling, emergency support, health care, and resource management. The second group of 32 worked with other forms of illness in the health care community providing the same services, but had no contact with PWAS. Instruments used were the Edwards Personal Preference Schedule (EPPS) and the Rotter Internal-External Control of Reinforcement Scale (Rotter I-E Scale). Subjects were given a research packet containing these instruments and a demographic background questionnaire to obtain information on age, sex, religious affiliation, marital status, caregiving population, number of care-hours per week, sexual orientation, and the subject's Human Immunodeficiency Virus status and subsequent diagnosis. Analysis of EPPS data indicated that AIDS caregivers had higher mean scores on the traits of Affiliation, Succorance, Nurturance, and Change. Non-AIDS caregivers had higher means scores on the traits of Order, Heterosexuality, and Aggression. There were no significant differences on the Rotter I-E Scale. (ABL)

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Select Personality Characteristic Differences Between Caregivers for Persons With Acquired Immune Deficiency Syndrome and Caregivers for Other Types of Illness

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ABSTRACT

Select Personality Characteristic Differences Between Caregivers for Persons With Acquired Immune Deficiency Syndrome and Caregivers for Other Types of Illness

The purpose of this study was to analyze select personality characteristics of individuals working within the Acquired Immune Deficiency Syndrome (AIDS) population in comparison to Non-AIDS caregivers by using two personality assessment instruments. Subjects were from two health care provider populations. The first group dealt only with Persons With AIDS (PWAS). They provided counseling, emergency support, health care, and resource management. The second group worked with other forms of illness in the health care community providing the same services, but had no contact with PWAS. The sample included 32 subjects in each group. Instruments used were the Edwards Personal Preference Schedule (EPPS) and the Rotter Internal-External Control of Reinforcement Scale. Subjects were given a research packet containing these instruments and a demographic Background Questionnaire to obtain information on age, sex, religious affiliation, marital status, caregiving population, number of care-hours per week, sexual orientation, and the subject's HIV status and subsequent diagnosis. The aim of this study was to gain descriptive data of personality traits of those persons working within the AIDS epidemic. Data were analyzed according to mean scores representing personality need traits measured by the EPPS for the AIDS and Non-AIDS caregivers using the ANOVA procedure. This analysis indicated that AIDS caregivers had higher means on the traits of Affiliation, Succorance, Nurturance, and Change. Non-AIDS caregivers had higher means on the traits of Order, Heterosexuality, and Aggression. According to demographic data, the typical AIDS caregiver was male, between 36 and 49 years of age, protestant, single, and homosexual and averaged 15 hours a week in client care. Three subjects from this group were HIV positive. Two subjects had a diagnosis of AIDS Related Complex (ARC), and one subject had a diagnosis of AIDS. The typical Non-AIDS caregiver was female, between 31 and 35 years old, protestant, married, and heterosexual and averaged 23 hours a week in client care. No subject had a diagnosis of ARC or AIDS. There were no significant differences between the groups on scores for the Rotter I-E Scale.

Acquired Immune Deficiency Syndrome (AIDS) was first identified as a disease in 1981 (Henig, 1983). In the United States alone, as of September, 1992, there are approximately 242,136 case of Full Blown AIDS. World wide there are an estimated 10 to 20 million cases of HIV infection. Providing care for individuals infected with Human Immunodeficiency Virus (HIV) presents unique difficulties never before faced by medical and social service systems.

Since the first years of the epidemic, a phenomenon has occurred to separate this health care problem from other approaches to providing care for patients. Many groups, both health providers and those politically oriented, have responded to the needs of individuals and communities hardest hit by AIDS. This response originally occurred without government or social service support. Gay communities in San Francisco and New York drew together as a viable force and began providing much needed care for AIDS-infected members. Pilot organizations, such as New York's Gay Men's Health Crisis and The San Francisco AIDS Foundation, took upon themselves the task of providing services for patients, services in the form of health care, emotional support, psychological consideration, and education for persons touched and those destined to be touched by the AIDS virus. These pilot organizations set the standard for numerous AIDS service organizations emerging all over the country. In the beginning most of these organizations were organized and run by volunteers and often by Persons With AIDS (PWAs).

The objective of this study was to examine select personality characteristics and demographic data of persons working with the AIDS disease population. This group was compared to those persons working with other disease populations. Three instruments were used: (a) The Edwards Personal Preference Schedule (EPPS) (Edwards, 1957) which is designed to measure a number of relatively normal, independent personality variables expressed as manifest needs, (b)The Rotter Internal-External Scale designed to indicate the perceived locus of control by individuals for life events. Subjects are presented with a series of alternate statements and must choose which is more appropriate in their perception. This is a forced-choice scale. Subjects must choose one

statement over another. The objective is to determine if a subject has an internal or external attribution for locus of control in viewing outside events, and (c) a Demographic Background Questionnaire.which was used to obtain information about the subjects such as age, sex, religious, affiliation, marital status, disease population, approximate number of care-hours per week, sexual orientation, and HIV status. It was originally hypothesized there would be statistically significant differences between AIDS and Non-AIDS caregivers on select personality variables as measured by the Edwards Personal Preference Schedule and that AIDS caregivers would have a more internal locus of control than Non-AIDS caregivers as measured by the Rotter Internal-External (I-E) Scale. Subjects were drawn from two groups of caregivers working within the health care community. Two hundred research packets were distributed to various AIDS and non-AIDS service organizations and health care facilities. Sixty-four of the packets were adequately completed to be used in data analysis. The return rate was 32%. Subjects in the first group, Group A, were composed of 32 professionals and volunteers who actively seek to work only with patients who have Acquired Immune Deficiency Syndrome (AIDS). These individuals who work with Persons With AIDS (PWAs) were from a variety of occupations, such as doctors, nurses, social workers, mental health clinicians, and personnel in AIDS service organizations. Subjects sampled in hospitals were taken from wards exclusively treating PWAs, such as Ward 64 at San Francisco General Hospital. The AIDS service organizations provide care and services for PWAs through professional and volunteer staff in the form of counseling, support groups, case management, staffing hot lines, and "buddy" assignments (where an individual PWA is assigned a volunteer to help with whatever needs the PWA may have, such as counseling, transportation for medical appointments, household tasks, etc.). Social workers, psychiatrists, and mental health clinicians worked as both paid staff and volunteers. Group B, the second group of subjects, was composed of 32 professionals and volunteers who work with seriously ill patients, but had no contact with PWAs or the AIDS epidemic by request or circumstance. These were also doctors, nurses, social workers, mental health clinicians, and volunteers. Subjects from hospitals provided services, such as

counseling, support groups, and limited medical assistance for the seriously ill. Again, social workers, psychiatrists, and mental health clinicians worked in these settings as paid staff or volunteers.

Data from the Demographic Background Questionnaire were compiled (see Table 1). The typical AIDS caregiver was male, between 36 and 49 years of age, protestant, single, and homosexual and averaged 15 hours a week in client care. Three subjects from this group were HIV-positive. Two subjects had a diagnosis of AIDS Related Complex (ARC), and one subject had a diagnosis of AIDS. The typical Non-AIDS caregiver was female, between 31 and 35 years of age, protestant, married and heterosexual, and HIV-negative and averaged 23 hours a week in client care. One subject in this group was HIV-positive. No subject had a diagnosis of ARC or AIDS. Mean scores for each of the variables measured by the Edwards Personal Preference Schedule (EPPS) and the Rotter I-E Scale were computed. The EPPS was scored according to established scoring criteria. Means for both groups on each variable were determined. A one-way analysis of variance was computed for each of the EPPS variables. Scoring for the Rotter I-E Scale was based on the number of responses to internal or external statements chosen. Higher scores are indicative of externality.

Table 1

Comparison of Demographic Variables for AIDS and Non-AIDS Caregivers

	AIDS	Non-AIDS
Age range	36-59	31-35
Sex		
Male	53%	16%
Female	47%	84%
Religion		
Protestant	50%	59%
Non-Protestant	19%	16%
None	31%	25%
Marital status		
Married	34%	56%
Single	53%	44%
Divorced	13%	0%
Sexuality		
Heterosexual	34%	91%
Homosexual	66%	6%
Bisexual	0%	3%
HIV status		
Positive	3	1
Negative	29	31
Diagnosis		
ARC	2	0
AIDS	1	0
Care hours	15 per week	23 per week

EPPS variables were ranked for each group (see Table 2). Rankings were from highest EPPS score to lowest. AIDS and Non-AIDS caregivers differed on rankings for each EPPS trait, except for the trait of Endurance which was ranked number 13 for both groups. A one-way analysis of variance was computed for each of the EPPS variables (see Table 3). The two groups of caregivers differed significantly, $p < .05$, on the variables of Order, Affiliation, Succorance, Nurturance, Change, Heterosexuality, and Aggression. A one-way analysis of variance was computed between the means of the groups on the Rotter I-E Scale (see Table 3). Results indicate the two groups did not differ significantly.

Table 2

Comparison of the Rank Order of Needs as Measured by the

EPPS for AIDS and Non-AIDS Caregivers

Needs		AIDS	Non-AIDS
Highest	1	Succorance	Heterosexuality
	2	Change	Dominance
	3	Intraception	Exhibition
	4	Nurturance	Achievement
	5	Exhibition	Aggression
	6	Autonomy	Intraception
	7	Heterosexuality	Succorance
	8	Dominance	Autonomy
	9	Affiliation	Order
	10	Achievement	Abasement
	11	Aggression	Change
	12	Abasement	Deference
	13	Endurance	Endurance
	14	Deference	Affiliation
Lowest	15	Order	Nurturance

Table 3

Analysis of Personality Variables

Needs	AIDS	Non-AIDS	F	Probability
Achievement	58.03	62.96	.45	.50
Deference	25.34	37.75	3.20	.07
Order	23.34	40.34	9.21	.00
Exhibition	65.81	63.75	.08	.76
Autonomy	64.21	56.37	1.36	.24
Affiliation	58.28	34.90	9.28	.00
Intraception	67.90	61.75	.81	.37
Succorance	72.15	57.00	5.84	.01
Dominance	59.34	67.53	1.39	.24
Abasement	29.93	39.46	2.24	.13
Nurturance	66.40	34.56	23.59	.00
Change	70.28	39.28	20.19	.00
Endurance	25.40	36.59	2.93	.09
Heterosexuality	60.21	76.18	9.67	.00
Aggression	41.93	62.62	8.80	.00
Locus of control	9.00	10.40	.28	>.05

Results indicate that a difference exists between the groups of AIDS and Non-AIDS caregivers profiled, according to demographic variables and select personality characteristics as measured by the EPPS. Such distinctions suggest several

considerations. The first is that conditions surrounding the AIDS epidemic have fostered the need for a different type of caregiver far removed from what might be considered the norm of caregiving populations, that some individuals may be better suited to work with certain disease populations, as in the case of AIDS, based upon specific factors in a caregiver's personality and demographic background. These specific factors may draw certain caregivers to work with the AIDS disease population. And, finally, certain types of caregivers, such as those working with PWAs, may be likely to function better in a caregiving situation when working with patients and populations with which they have more in common and where rapport is easily established. These results suggest that personality characteristics and demographic variables of caregivers tend to draw these persons to work with specific disease populations, such as PWAs.

In profiling the two caregiving populations, it is evident the two groups do differ on some demographic factors. Demographic variables taken from the Demographic Background Questionnaire indicate the typical AIDS caregiver may be described as male, between 36 and 49 years of age, single, homosexual, and HIV-negative and averages 15 hours a week in work with PWAs. This differs somewhat from the description of the typical Non-AIDS caregiver. These individuals can be described as female, between the ages of 31 and 35 years, married and heterosexual, HIV-negative, and averaging 23 hours a week in caregiving for her patients. It must be understood that these descriptions are taken from reported demographic information from persons participating in this study. This does not imply these populations are staffed only with these types of individuals. However, because the AIDS organizations sampled were from both the southeast and the upper west coast of the United States comprising a wide range of AIDS service groups, it appears there will be consistency among demographic variables for AIDS caregivers.

The historical perspective of AIDS readily explains the demographics of the caregiving population for PWAs. As stated earlier in this paper, AIDS began in the gay community and is still an enormous factor in the lives of most gay men. It is not unusual to find a great many of the people caring for PWAs to be from that community. However,

there is more that separates AIDS and Non-AIDS caregivers than demographics. Results from the Edwards Personal Preference Schedule indicate there are statistically significant differences in the personality profiles of these two groups. The Edwards Personal Preference Schedule is designed to measure a series of traits or manifest needs. Scores are expressed as percentage means in comparison to standardized scores of a norm population. It is possible to profile an individual or group according to these traits. This has been done in two ways. The first was to rank EPPS need traits from highest to lowest score as seen in Table 2. Edwards (1957) states that those EPPS traits having higher scores reflect the stronger personality characteristics of an individual or group. In considering that higher scores reflect stronger need traits of personality and lower scores reflect the less important needs, it is possible to compare EPPS results of the two groups. AIDS and Non-AIDS caregivers differ on rankings for every EPPS need trait, except for the trait of Endurance which is ranked number 13 for both groups. When the spread of rankings is looked at as a whole, it appears the two groups are almost in opposition in trait profiles. The highest rankings of EPPS variables provide the best clues into the prominent personality characteristics of an individual or group. The EPPS need traits of Succorance, Change, Intraception, and Nurturance were highest for the AIDS caregivers, and the groups differed significantly on three of the four (all except Intraception). Such rankings would indicate AIDS caregivers have a strong commitment to others and are very emotionally involved in their work. AIDS caregivers have a strong sense of community and provide support through their involvement and efforts to provide care for its ill members. They appear to have a positive self-image. They are clearly dependent on others in their lives and place great emphasis on friendships and loved ones. This group also appears less driven by outside forces, such as career, status, or power as indicated by lower rankings of aggression, achievement, and dominance, though the groups differed significantly only on one of the three (Aggression). Needs usually associated with accomplishment and career apparently have less influence in the lives of these caregivers. It appears that many persons from this group are not career-oriented and place little value on large material gain. AIDS caregivers appear

compassionate, nurturant, and benevolent in their actions. They do not appear conservative in social and moral views. They probably do not blindly accept the conventional and established views outside their own community. It would be expected that AIDS caregivers are more flexible in their attitudes and tolerant of others and demands in their attempts to work with an often unaccepting social system.

The EPPS need traits which have the higher rankings for Non-AIDS caregivers are Heterosexuality, Dominance, Exhibition, Achievement, and Aggression. The groups differed significantly only on two of the five (Heterosexuality and Aggression). These caregivers appear to be very individualistic. Persons from this group probably function well in established social systems. Ambiguity in sex roles would not surface in this group. They appear more conservative and adhere strongly to heterosexual attitudes. It can be said that Non-AIDS caregivers exhibit a high desire to achieve. They appear more independent that AIDS caregivers. Results indicate that Non-AIDS caregivers are probably more career-oriented. Their involvement with seriously ill patients may stem more from occupational rather than personal reasons. Lower rankings of Affiliation and Nurturance, both of which were significant differences between the groups, may indicate that this group relies less on friendship and other outside sources of emotional support than AIDS caregivers. This is understandable considering that most Non-AIDS caregivers are married and have families. Non-AIDS caregivers also appear less socialized than AIDS caregivers. These caregivers probably do not get as emotionally involved with their clients.

A one-way analysis of variance was used to determine the statistically significant differences between these groups on EPPS need traits. Order is one of these need traits which statistically separates AIDS and Non-AIDS caregivers. Order can be described (Edwards, 1957) as a desire to have work neat and organized, to make plans before starting a difficult task, to make advanced plans. Non-AIDS caregivers had a higher mean (40.34) score for this need trait than AIDS caregivers (23.34). One explanation for such a score may be because most Non-AIDS caregivers are professionals in various hospitals, health-care agencies, and hospices. Their services are provided according to

well-established guidelines and procedures. These methodologies existed long before the arrival of these caregivers and are used by most other facilities of this type. Very little ambiguity exists in how these persons perform their jobs. They are able to look to co-workers and supervisors for guidance and rely less on imagination in deciding how to care for their patients. It would be expected that such a sense of order would extend to the personal lives of these caregivers. Order would be needed in the personal lives and relationships of these caregivers to cope with family and career pressures. These individuals have worked long and hard in many years of schooling and training to reach their positions. For AIDS caregivers order is less important. As stated earlier, the gay community, before the advent of AIDS, was largely defined by their sexual activity. There was little continuity to pull this minority group together, except for occasional political activism. Order, for the community or even in their personal lives, was not a priority. When AIDS began its spread through the gay community, this minority group, who had celebrated sexual freedom for many years, suddenly found themselves dealing with a situation for which they were totally unprepared. Many AIDS service organizations have been in existence for less than fives years, few longer than eight or ten. Most of these groups began as grassroots organizations. They developed policies and procedures without benefit of examples to follow. Staffing was by volunteers performing many jobs at the same time. AIDS has had a sobering effect on the gay community. One perspective is that order is being forced on the community as it struggles with the AIDS crisis. It is evident that AIDS organizations function due to the needs of the communities they serve. Order and maturation are slowly becoming a part of the gay community. The continued existence of AIDS service organizations in the gay community and the lower incidence of new HIV infection among gay men prove this is happening.

Affiliation is another need trait significantly different for these caregiving groups. Affiliation can be described (Edwards, 1957) as a need to be loyal to friends, to do things for friends, to share things with friends. AIDS caregivers had the higher mean for this trait (58.28), Non-AIDS having the lower (34.90). It is important to examine

the role of friendship for the heterosexual and gay communities. For the gay man or lesbian, friendship is very important. Both gay men and lesbians have a strong desire to value and culture friendship because of its necessity in their lives. Unlike many heterosexuals who pour most of their emotional energies into husbands, wives, and children, gay persons have only those close friends and lovers with which to share their lives. Issues of personal hopes and doubts, health concerns, emotional and spiritual growth, and personal goals can many times only be discussed with other homosexuals. Heterosexuals are often so rooted in marriage and involvement with family that they need very little sustenance from friends. Activity in AIDS organizations draws its motivation from affiliation in the gay community. These individuals are caring for friends who are ill. For gay men and lesbians, friendship is not a makeshift or substitute for love, but is the basis of their community. It is crucial to the happiness and well-being of most gay men and lesbians. Pains are taken to make friendship thrive.

Succorance is another need trait to significantly separate these groups. This need trait can be described (Edwards, 1957) as a need to have others provide help when in trouble, to have others be sympathetic and understanding. AIDS caregivers had the higher mean for this trait (72.15), with Non-AIDS having the lower (57.00). For AIDS caregivers it can be understood how much the AIDS epidemic has fostered a strong dependence on others. AIDS workers face monumental emotional and psychological stressors in their work. Many AIDS caregivers are unable to have a professional detachment with their clients. A large percentage of these workers may find themselves in the same position as their patients, and this places tremendous pressures on these caregivers. It takes a great deal of strength to work in such a situation. Most caregivers find they must become involved in support organizations and groups to deal with the emotional turmoil of caring for PWAs. Such dependence on these sources of support and understanding is vital in continuing to provide quality care for their patients. Non-AIDS caregivers are able to turn to those sources of support existing in marriage and family, support sources which are not available to most gays and lesbians.

The need trait of Nurturance also significantly separated these groups. Nurturance can be described (Edwards, 1957) as a measure of the need trait to assist others with kindness and sympathy, to provide care for those who are hurt or sick. Nurturance would be considered as one of the most important traits when working with seriously ill clients. It would be assumed these two groups would not differ much in their scores; however, this is not the case. AIDS caregivers had a much higher mean (66.40) than Non-AIDS caregivers (34.56). AIDS caregivers often serve multiple roles as friend, counselor, housekeeper, and nurse. Considering the immense time commitment in working with PWAs, such a high score for Nurturance is understandable. AIDS caregivers tend to be non-professionals in a volunteer setting. This indicates a personal interest vested in their work. The Nurturance score for the Non-AIDS caregivers is surprising. This is even more evident in the ranking it received on Table 2. Nurturance is ranked last in importance for the Non-AIDS caregiver. One would consider Nurturance to be a very strong personality trait for someone providing care for seriously ill patients. Most Non-AIDS caregivers were married and had families. This group also reported more hours devoted to direct patient care. Such a low score is very unusual. One possible explanation is that this score may be a reflection of working with clients in a more professional capacity than AIDS caregivers. Professionalism may tend to distance the caregiver from the client.

Change is another need trait to separate AIDS and Non-AIDS caregivers. This need trait may be described (Edwards, 1957) as a desire to do new and different things, to experience novelty and change in daily routine. AIDS caregivers had the higher mean (70.28) for this trait; Non-AIDS had the lower mean (39.28). Working within AIDS organizations, a caregiver sees a great deal of change and unusual conditions. Sadly, this is often in the case of high client turnover. Although AIDS patients are living longer due to new therapies and treatments, swift, unexpected deaths do occur. An AIDS worker must be adaptable to constantly changing situations. They may be called upon to do any number of tasks from changing I.V. drips to preparing meals or comforting a patient or grieving family. Because AIDS is a newly recognized illness, there is a great deal of

mystery and fascination in the clinical aspects of the disease. AIDS has become "THE" disease of the late 20th century. Working with the epidemic is a challenging and rewarding experience, carrying prestige and admiration for those willing to be involved. Noted celebrities crusade to fight the stigma and prejudice of AIDS. The AIDS epidemic tends to thrust any person involved into the spotlight. Change may not be as important to an established professional, such as the Non-AIDS caregiver. This group carries the responsibility of family and career. They appear to live more conventional lives with little opportunity for major life change. AIDS caregivers may view life as tenuous. Frequent deaths and frustration with their limited ability to actually ease the suffering of their clients may cause these caregivers to view major change as a normal factor in their lives.

Heterosexuality is one of the EPPS need traits that would be expected to separate these groups of caregivers. Heterosexuality can be described (Edwards, 1957) as a desire to associate with members of the opposite sex, to be attracted to members of the opposite sex, to desire sexual contact with members of the opposite sex. Non-AIDS caregivers clearly had the higher mean (76.18) than AIDS caregivers (60.21). Most Non-AIDS caregivers were heterosexual, as indicated by data from the demographic questionnaire. However, this score may be influenced by another factor, specifically, a reluctance by these caregivers to be involved with AIDS patients. A criterion in recruiting subjects for the Non-AIDS group was that subjects must have had no contact with an AIDS patient either through request or circumstance. Since AIDS is often seen as a homosexual disease, many individuals may be reluctant to be involved with the illness because of the stigma of homosexuality. Such a high mean for heterosexuality may be an indicator for reluctance in working with PWAs. AIDS caregivers had an unusually high score for this EPPS trait. AIDS caregivers are predominantly homosexual. It would be expected that their score and ranking for heterosexuality would be much lower than results indicate.

Aggression is another EPPS need trait that significantly separates these groups of caregivers. This need trait can be described (Edwards, 1957) as a need to attack

contrary points-of-view, to tell others what one thinks, to criticize others, to blame others when things go wrong. Non-AIDS caregivers have the higher mean (62.62) for this need trait, with AIDS caregivers having the lower mean (41.93). Such a strong trait in personality may be needed for Non-AIDS caregivers in their job performance. It may be necessary for maintaining a professional attitude. Most of the Non-AIDS caregivers are paid staff in the various hospitals, health-service organizations, and hospices. Aggression is very important in career advancement and job performance. This group often had families to support. Food, clothing, housing, and education can be costly when it is being provided for many people in a household. AIDS caregivers are not pressured by this factor. Most have no children and never will. The majority of homosexuals who are together in a relationship have two incomes. Economics is not necessarily a worry.

The history of AIDS may provide some explanation of why AIDS caregivers are so different from the typical population of caregivers. Most persons infected by AIDS in the beginning of this epidemic were homosexual men. The disease was initially identified as a "Gay Plague," brought about by the practice of homosexual activity. Initially, AIDS was largely ignored by the United States government and health care agencies. In the early years of the epidemic, it became evident that if care was to be provided for HIV-infected persons, then such care had to come from somewhere besides the usual social service and medical resources. This original care for PWAs came from within the community the disease hit the hardest, the gay community, which is a very specific, well-defined, and contained subculture with its own language, mores, and social identity. Most of these grassroots AIDS organizations began in gay communities supported by funding from persons living in those areas. For these reasons it is not unusual to find gay men and lesbians still providing most of the care for PWAs and support for these organizations through funding and political action. It must be realized how interwoven AIDS is in the fabric of gay life. AIDS initially struck the older male homosexual population, those persons sexually active the longest. As these men began to die, and infection spread over a wider age range, the disease slowly became an intricate part of

every gay man's life. Today, it is quite common for most gay men to report knowing 10 to 15 friends who have died from AIDS-related infections. AIDS is still seen by many people as a homosexual disease. This belief system exists despite scientific evidence that AIDS is a very difficult disease to contract and has no sexual, racial, or ethnic boundaries. What distinguishes the gay community in their response to the AIDS epidemic is their realization that AIDS probably will not disappear in the near future.

Such a response to the health crises presented by AIDS may be explained by the cohesiveness in the gay community which comes from a variety of sources. One must consider that, unlike heterosexuals, the gay man or lesbian does not have the support of conventional family or marriage. Homosexual relationships and unions are not sanctioned by most churches or carry legal support. Few laws exist which protect the "out" homosexual man or woman. Any individual, regardless of sexual orientation, needs a sense of social approval and support to maintain mental health and positive self-image. For many gay men and lesbians, these needs are met primarily by the homosexual community, which is just as varied and diverse as its heterosexual counterpart. Both gay men and lesbians tend to form surrogate families of close friends and lovers which create a vehicle to survive hardship and provide support throughout life. Energies and economic support are turned to an environment where gay individuals are welcomed and nurtured for their gayness. Historically, communities are protective of their own, be they bound by skin color, religion, politics, or in the case of the gay community, a person's sexual orientation. Today, that community is threatened by the real dangers of AIDS. The gay adolescent having to deal with the pressures of sexual orientation must also carry the burden of the threat of AIDS. AIDS has united the gay community to a common cause, creating continuity in a social minority, who were only defined by their sexual activity. Those caring for PWAs have probably done so since the epidemic began. Many AIDS caregivers are HIV-positive or may have AIDS themselves. They see their work as not only caring for another individual in need, but caring for themselves as well.

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